

State Implementation of the Optional Provisios of the Deficit Reduction Act

Julia Belian
University of Missouri- Kansas City

Follow this and additional works at: <http://scholarship.law.marquette.edu/elders>



Part of the [Elder Law Commons](#)

Repository Citation

Belian, Julia (2007) "State Implementation of the Optional Provisios of the Deficit Reduction Act," *Marquette Elder's Advisor*: Vol. 9: Iss. 1, Article 4.

Available at: <http://scholarship.law.marquette.edu/elders/vol9/iss1/4>

This Article is brought to you for free and open access by the Journals at Marquette Law Scholarly Commons. It has been accepted for inclusion in Marquette Elder's Advisor by an authorized administrator of Marquette Law Scholarly Commons. For more information, please contact megan.obrien@marquette.edu.

STATE IMPLEMENTATION OF THE OPTIONAL PROVISIONS OF THE DEFICIT REDUCTION ACT

Julia Belian*

Although mandated by federal law, Medicaid always has been fundamentally a matter of state business, primarily because states administer the program and receive only partial federal reimbursement for state expenditures.¹ As is true with any federally mandated state expense, Medicaid must arbitrate the inherent tension between the fairness of nationwide uniformity and the practicability and political expediency of requiring local populations to pay for benefits that they may not otherwise afford or want to provide.²

Consequently, Medicaid law has always included two types of federal mandates.³ First, states are required to provide certain benefits in their Medicaid programs.⁴ Second, states can choose to provide additional benefits, and thus, states so inclined and whose budgets so allow, can provide more than the minimum

* Julia Belian is a Visiting Associate Professor of Law at the University of Missouri-Kansas City. She received a B.A. cum laude from Southwestern University in 1980, a Master of Divinity degree from Yale University in 1993, and a J.D. with distinction from Emory University School of Law in 1996. The author wishes to thank Aubrey Gann for her dedicated and able research assistance on this article and Brant McCoy for his assistance with research for earlier drafts of this article.

1. ELICIA HERZ ET AL., CRS REPORT FOR CONGRESS, HOW MEDICAID WORKS: PROGRAM BASICS 1 (2005), available at <http://kuhl.house.gov/UploadedFiles/medicaidworks.pdf>.

2. Rep. Michael R. Turner, *Deficit Reduction Act and Medicaid Reform: Independent Necessities*, U.S. FEDERAL NEWS, Dec. 2, 2005 [hereinafter *Independent Necessities*].

3. See HERZ ET AL., *supra* note 1, at 18.

4. *Id.* at 18-19.

benefits to their citizens.⁵ This two-tiered system of standards arguably produces two desirable outcomes: states less willing or able to fund health care services must provide minimum benefits in order to receive any federal reimbursement, while states that want to offer additional benefits are limited in what they can offer at the federal government's shared expense.⁶ The resulting range of required and permitted benefits means that a Medicaid beneficiary's available benefits vary depending on where he or she lives.⁷ In addition, Medicaid law has always left administration of Medicaid programs to the states, and many administrative details can differ substantially from state-to-state.⁸

The waiver process is a third component that adds to the variance of Medicaid programs among the states.⁹ Waivers permit a state to receive federal reimbursement despite its nonconformance with federal standards.¹⁰ Prior to the Deficit Reduction Act (DRA), three sections of the Social Security Act granted primary authorization for waiver programs: sections 1915(b), 1915(c), and 1115.¹¹

Section 1915, as codified at 42 U.S.C. § 1396n, is relatively narrow in scope.¹² Subsection 1915(b) authorizes waivers that

5. *Id.* at 18-21.

6. *See id.* at 1-2, 18-19.

7. *Id.* at 19-21.

8. *See id.* at 33.

9. *Id.* at 23-24, 43-48.

10. *Id.* at 43-44; *see also* KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID SECTION 1115 WAIVERS 1-2 (2005), <http://www.kff.org/medicaid/upload/Medicaid-Section-1115-Waivers-Current-Issues-pdf.pdf> (last visited Sept. 26, 2007) [hereinafter MEDICAID SECTION 1115 WAIVERS].

11. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MANAGED CARE/FREEDOM OF CHOICE WAIVERS - SECTION 1915(B), [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/04_ManagedCare_FreedomofChoiceWaivers-Section1915\(b\).asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/04_ManagedCare_FreedomofChoiceWaivers-Section1915(b).asp) (last visited Sept. 26, 2007) [hereinafter MANAGED CARE/FREEDOM OF CHOICE] (discussing section 1915(b) waivers); HERZ ET AL., *supra* note 1, at 43-48 (discussing Section 1115 and Section 1915(c) waivers). *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 42 U.S.C.) (Westlaw current through Sept. 26, 2007). Sections 1916(b) and 1915(c) waivers are codified at 42 U.S.C.A. § 1396n. Section 1115 waivers are codified at 42 U.S.C.A. § 1315. *See* MEDICAID SECTION 1115 WAIVERS, *supra* note 10, for a discussion about other statutory waivers less germane to this discussion.

12. *See* 42 U.S.C.A. § 1396n; *See also* HERZ ET AL., *supra* note 1, at 43-45;

allow states to limit Medicaid recipients' choice of providers under a managed care program.¹³ Subsection 1915(c) permits state programs to provide long-term care services in non-institutional settings like home and community-based services programs (HCBS programs).¹⁴ Section 1915 waiver options have proven immensely attractive to the states; as of the writing of this article, approximately thirty-three states have one or more 1915(b) waiver programs,¹⁵ while forty-eight states and the District of Columbia have utilized some form of a 1915(c) waiver, which has created a total of 287 HCBS programs.¹⁶

By contrast, section 1115 authorizes a variety of waivers termed "Research and Demonstration Projects."¹⁷ The goal of section 1115 is to encourage state program innovation in hopes that states will discover more efficient ways to provide health care services to the nation's poor.¹⁸ The broad waivers that are possible under section 1115 permit states to make significant program revisions without the delay or political challenge involved with a federal statutory amendment.¹⁹

As health care costs have burgeoned over the past few decades, interest in waiver programs has increased.²⁰ States have encountered growing pressure on numerous areas of their

MANAGED CARE/FREEDOM OF CHOICE, *supra* note 11, at 1.

13. MANAGED CARE/FREEDOM OF CHOICE, *supra* note 11, at 1.

14. HERZ ET AL., *supra* note 1, at 46.

15. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID WAIVERS AND DEMONSTRATIONS LIST, <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp> (last visited Sept. 26, 2007) [hereinafter WAIVER AND DEMONSTRATIONS LIST].

16. *See id.* *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., HCBS WAIVERS - SECTION 1915(c), http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCB SWaivers-Section1915(c).asp (last visited Sept. 26, 2007).

17. HERZ ET AL., *supra* note 1, at 43-44; MEDICAID SECTION 1115 WAIVERS, *supra* note 10, at 1.

18. *See* HERZ ET AL., *supra* note 1, at 43-44.

19. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., RESEARCH & DEMONSTRATION PROJECTS - SECTION 1115, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp (last visited Sept. 26, 2007).

20. HERZ ET AL., *supra* note 1, at 43; Christie Raniszewski Herrera, Dir., Health and Human Servs. Task Force, Am. Legislative Exch. Counsel, Statement before the Kentucky Medicaid Oversight Committee (Aug. 28, 2006), available at http://www.alec.org/meSWFiles/pdf/HHS/KY_Testimony_Text.pdf.

economies and budgets, and in response, they increasingly desire permissible ways to reduce Medicaid costs.²¹ By 2005, the Centers for Medicare and Medicaid Services (CMS) granted twenty-seven states and the District of Columbia section 1115 waivers, which allowed the states to make comprehensive program changes.²² States have also lobbied intensely for increased flexibility within federal Medicaid standards.²³ In turn, the federal government, while likewise struggling with expanding costs, has made numerous efforts to expand waiver initiatives.²⁴ Although waiver programs were originally conceived as a way to test new methodologies of coverage and service delivery, they have gradually developed into methods of reducing coverage with the hope of limiting costs.²⁵ Section 1115 waivers have allowed states to alter fundamental aspects of federal Medicaid standards, including enrollment, coverage, and benefits.²⁶

However, critics have argued that section 1115 waivers are inadequate.²⁷ States have continued to press for even more flexibility.²⁸ Critics have maintained that the section 1115 waiver process is exceedingly cumbersome and difficult, and thus can delay or discourage state innovation.²⁹ There also developed a demand for broader changes to the substantive

21. See HERZ ET AL., *supra* note 1, at 43-44.

22. WAIVER AND DEMONSTRATIONS LIST, *supra* note 15.

23. See, e.g., Editorial, *Premiums for the Poor*, WASH. POST, Aug. 1, 2005, at A16, available at <http://www.washingtonpost.com/wp-dyn/content/article/2005/07/31/AR2005073100804.html> (discussing how state governments want authority to impose premiums, co-payments, and cost sharing onto Medicaid beneficiaries).

24. KAISER COMM'N ON THE FUTURE OF MEDICAID, RESTRUCTURING MEDICAID: KEY ELEMENTS AND ISSUES IN SECTION 1115 DEMONSTRATION WAIVERS (May 1997), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14726> (last visited Sept. 26, 2007) [hereinafter KFF RESTRUCTURING MEDICAID]; see HERZ ET AL., *supra* note 1, at 43-48.

25. HENRY J. KAISER FAMILY FOUND., WHERE IS MEDICAID SPENDING HEADED? 1 (1996), <http://www.kff.org/Medicaid/2074-forecast.cfm> (last visited Sept. 26, 2007).

26. See HERZ ET AL., *supra* note 1, at 43.

27. Herrera, *supra* note 20.

28. KFF RESTRUCTURING MEDICAID, *supra* note 24, at 2.

29. Herrera, *supra* note 20 (noting that "even CMS admits that this lengthy process [of applying for Section 1115 waivers] makes it harder for states to be innovative with their Medicaid programs.").

federal Medicaid standards.³⁰ The push for Medicaid reform is evident in the DRA, which developed out of this atmosphere.³¹ The DRA was crafted, in part, as a response to state-level dissatisfaction with existing waiver options.³² Pressure to increase state flexibility culminated on February 8, 2006, when President George W. Bush signed the DRA, Senate Bill 1932, into law.³³

The DRA spells significant changes for Medicaid, as it institutes deep revisions of some of the program's core elements.³⁴ The most significant components of the DRA's reforms include the expansion of state options and the simplification of the option approval process.³⁵ This article examines the newly available options that will most notably affect Medicaid services to the elderly, especially long-term care, and it summarizes program revisions under consideration or active development.³⁶

30. *See id.*

31. *See* Pub. L. No. 109-171, 120 Stat. 4, 121-127 (Westlaw current through Sept. 26, 2007).

32. *Independent Necessities*, *supra* note 2.

33. *See* Press Release, Office of the Press Secretary, President Signs S. 1932, Deficit Reduction Act of 2005 (Feb. 8, 2006), available at <http://www.whitehouse.gov/news/releases/2006/02/20060208-8.html>. *See also* JEFFREY S. CROWLEY, MEDICAID LONG-TERM SERVICES REFORMS IN THE DEFICIT REDUCTION ACT 2 (Kaiser Comm'n on Medicaid and the Uninsured ed., 2006), <http://www.kff.org/medicaid/upload/7486.pdf> (last visited Sept. 26, 2007).

34. JUDITH SOLOMON, CTR. ON BUDGET AND POLICY PRIORITIES, THE ILLUSION OF CHOICE: VULNERABLE MEDICAID BENEFICIARIES BEING PLACED IN SCALED-BACK "BENCHMARK" BENEFIT PACKAGES 1-2 (Sept. 14, 2006), available at <http://www.cbpp.org/9-14-06health.pdf>; Herrera, *supra* note 20.

35. Herrera, *supra* note 20.

36. This article does not attempt to scrutinize every DRA provision. Provisions not discussed herein also have the potential to affect elders. However, this article focuses on the provisions that appear most likely to affect elders immediately and most profoundly, and those that are likely to affect elders in ways not necessarily apparent from the law's text. This article also does not discuss state implementation of mandatory DRA provisions. While implementation of mandatory provisions has been somewhat uneven to date, states will implement them, and there exists only mild uncertainty as to when and what section of the state code or regulations will incorporate the provisions. Moreover, because this area is subject to rapid change especially at the state level, it should be presumed this article will be outdated in certain key aspects as soon as it appears in print. This article attempts to offer a convenient summary and starting point for further research, and the author is under no delusion that it is, or could be, an exhaustive

CHANGES TO THE OPTIONS PROCESS

The DRA has made available to state Medicaid programs new methods by which to alter their services. It is important to look at the methods available prior the DRA's passing because while the DRA created additional methods for obtaining federal standard waivers, but it did not remove any of the methods already available.

THE STATE PLAN AMENDMENT

Prior to enactment of the DRA, a state that wanted to test a new Medicaid plan approach had to seek a waiver under a section of the law authorizing the desired approach.³⁷ The only exception to this general rule was the possibility of broad program changes that were approved under a Section 1115 waiver, where revisions are designed to be experimental and to provide outcomes for the CMS to consider in future Medicaid policy debates.³⁸ Section 1115 waivers have the advantage of wide potential application, and they have the distinct disadvantage of administrative uncertainty and difficulty³⁹. The text of section 1115 is not especially helpful to states when they are deciding precisely how to prepare a waiver proposal.⁴⁰

State requests to make changes under the DRA State Plan Amendment process (DRA-SPA process) can still be quite bulky.⁴¹ Nevertheless, aspects of the new approach seem to promise streamlining of the process.⁴² First, at a conceptual level, CMS does not approve SPAs under the guise of "Research

analysis.

37. Herrera, *supra* note 20.

38. See MEDICAID SECTION 1115 WAIVERS, *supra* note 10.

39. See Herrera, *supra* note 20.

40. See Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. § 1315).

41. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., STATE PLAN AMENDMENTS, http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp#TopOfPage (last visited Sept. 26, 2005) (follow Kentucky hyperlink) [hereinafter STATE PLAN AMENDMENTS]. The Kentucky SPA submission is 116 pages long. See *id.*

42. Herrera, *supra* note 20.

and Development.”⁴³ In addition, the DRA-SPA process is more clearly defined than the waiver process.⁴⁴ The SPA proposal form is clearly laid out, as it positions the statutorily approved options with checkboxes and provides additional space to provide narrative descriptions, if necessary.⁴⁵

States have generally liked the more defined and expedited process, as well as the idea that certain substantial program changes are *per se* permitted without the state having to justify changes that are not merely experimental.⁴⁶ While at present only five states have actually submitted SPA proposals to CMS, dozens more have directed state agencies to develop such amendments, to submit them to CMS, and to take action as quickly as possible once CMS approves the proposals.⁴⁷ The DRA-SPA process and forms offer a “buffet approach,” allowing state legislatures to efficiently present desired changes for consideration, and the specificity of authorized program changes in the DRA allows state agencies to know what information CMS needs in order to approve a SPA.⁴⁸

OTHER STATE OPTION PROCESSES

States can use the simplified DRA-SPA process to submit most substantive program changes newly authorized by the

43. *Id.*

44. See generally J.P. PETERS, CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID STATE PLAN PROCESS: AN OVERVIEW (2006), http://www.trha.org/conference_2006/Medicaid%20State%20Plan%20Process.ppt. (last visited Sept. 26, 2007) (discussing the process of submitting a SPA, SPA review, notice of action, and requests for reconsideration under the DRA).

45. See Herrera, *supra* note 20.

46. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., THE DEFICIT REDUCTION ACT: IMPORTANT FACTS FOR STATE GOVERNMENT OFFICIALS, <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Checklist1.pdf> (last visited Sept. 23, 2007) (providing guidelines for states for how to understand and implement the Deficit Reduction Act's changes) [hereinafter IMPORTANT FACTS].

47. See CTRS. FOR MEDICARE & MEDICAID SERVS., ROADMAP TO MEDICAID REFORM, <http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/LTC%20Roadmap%20to%20Reform.pdf> (last visited Sept. 26, 2007) [hereinafter ROADMAP]; See State Plan Amendments, *supra* note 41 (select individual state hyperlinks).

48. See generally IMPORTANT FACTS, *supra* note 46 (providing guidelines for states for how to understand and implement the Deficit Reduction Act's changes).

DRA.⁴⁹ The DRA still allows CMS to approve of other new options through more familiar methods, including section 1115 waivers.⁵⁰ States must use section 1115 waivers to approve Health Opportunity Accounts programs⁵¹ and to apply for certain grants designed to defray costs of developing other DRA-authorized programs or changes, such as those set forth in section 6071 ("Money Follows the Person" Grants)⁵² or section 6043 (Non-Emergency Service Grants).⁵³ Section 6081's "transformation grant" is a newly available federal grant that by January 2007 generated thirty-two grants to twenty-six states, totaling \$103 million.⁵⁴

It is important to remember that the DRA created additional methods for obtaining waivers of federal standards, but it did not remove any of the methods already available.⁵⁵ Thus, states still may submit proposals for waivers under section 1915(b), section 1915(c), section 1115, or any other previously existing waiver statutory authority.⁵⁶ This is important because although certain substantive changes newly authorized under the DRA-SPA process are administered with certain limitations or safeguards, states can submit a request under section 1115 to make changes analogous to those authorized under the DRA and without the DRA-specified limitations imposed on them.⁵⁷

For example, in late 2005, CMS approved a major overhaul

49. See ROADMAP, *supra* note 48, at 1.

50. See MEDICAID SECTION 1115 WAIVERS, *supra* note 10, at 1.

51. 42 U.S.C.A. § 1396(u-8, v); see *infra* notes 222-43 and accompanying text.

52. § 1396(a); see CTRS. FOR MEDICARE & MEDICAID SERVS., MONEY FOLLOWS THE PERSON GRANTS, http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp#TopOfPage (last visited Sept. 23, 2007) [hereinafter MONEY FOLLOWS THE PERSON GRANTS]; see *infra* notes 155-60 and accompanying text.

53. § 1396(o)-1; see CTRS. FOR MEDICARE & MEDICAID SERVS., GRANT FUNDS FOR ALTERNATE NON-EMERGENCY SERVICES PROVIDERS, <http://www.cms.hhs.gov/GrantsAlternaNonEmergServ/> (last visited Sept. 26, 2007) (an example of another grant requiring use of the Section 1115 waiver process).

54. U.S. DEP'T OF HEALTH AND HUMAN SERVS., GRANT AWARDS (Jan. 25, 2007), http://www.cms.hhs.gov/MedicaidTransGrants/02_012507awards.asp#TopOfPage (last visited Sept. 26, 2007).

55. See Pub. L. No. 109-171, 120 Stat. 4.

56. See HERZ ET AL., *supra* note 1, at 43-48.

57. See *id.*

of Florida's Medicaid program under a section 1115 waiver.⁵⁸ Although the changes to Florida's plan are geographically limited to a few experimental counties at present, the changes generally parallel many changes authorized under the DRA, but also go significantly beyond the DRA's limitations.⁵⁹ CMS found Florida's revisions acceptable because the state submitted the revisions under section 1115, not under the DRA-SPA process.⁶⁰ And make no mistake - Florida does not intend to limit changes to the selected counties forever, and instead plans to implement changes statewide at the earliest opportunity.⁶¹ Consequently, the DRA could result in a kind of synergy between the section 1115 waiver and the DRA-SPA process; CMS may accept changes to programs under section 1115 that normally would be authorized with limitations under the DRA, even when the request does not include the limitations required under the DRA.⁶²

NEW SUBSTANTIVE PROGRAM OPTIONS AFFECTING LONG-TERM CARE

The DRA has made available to states new program options that are of particular interest to states as discussed in the sections that follow. First, section 6021 of the DRA allow states to adopt Long-Term Care Insurance Partnership Programs, which impact seniors who foresee a need for skilled nursing care. Second, states can use section 6086 to make it easier for seniors to obtain Home and Community-Based Services. Section 6087 established a new state option for self-directed personal assistance services (PAS), which enables states to offer Home and Community-Based Services beneficiaries personal assistance. Lastly, section

58. JOAN ALKER & LISA PORTELLI, UNDERSTANDING FLORIDA'S MEDICAID REFORM LEGISLATION 1 (Winter Park Health Found. ed., 2005), available at <http://www.wphf.org/pubs/briefpdfs/Medicaid4.pdf>.

59. *See id.*

60. *See id.*

61. *See generally id.* at 2 (noting that the participating county programs are "demonstration pilots").

62. *See id.*

6071 provides grants to states that seek to provide services to beneficiaries who move out of institutions and into the community.

**SECTION 6021 – QUALIFIED LONG-TERM CARE INSURANCE
PARTNERSHIP PROGRAMS**

Section 6021 of the DRA expands authority for Long-Term Care Insurance Partnership Programs (LTCIP Programs),⁶³ and it is has arguably generated the most interest and activity among the states. Section 6021 appears to be the one DRA section that most directly affects seniors, especially those who may need long-term care in a skilled nursing facility.⁶⁴

In the early 1980s, states began to search for a method to shift payment of long-term care to a private insurance-based model, which eventually led to development of a LTCIP Program under an initiative sponsored by the Robert Wood Johnson Foundation.⁶⁵ Under the waiver authority of § 1902(r)(2), five states – California, Connecticut, Indiana, Iowa and New York – established pilot programs in the early 1990s.⁶⁶ These early programs adopted one of two approaches, either the “Dollar for Dollar” approach or the “Total Asset Protection” approach.⁶⁷

Under the “Dollar for Dollar” approach, which California and Connecticut implemented, a policyholder can shield assets equal to the benefits paid under the policy purchased from spend-down.⁶⁸ Although the shielded assets might still be

63. See 42 U.S.C.A. § 1396(p) (Westlaw current through Sept. 26, 2007).

64. See generally *id.*

65. Alexis Ahlstrom et al., *The Long-Term Care Partnership Program: Issues and Options*, RETIREMENT SERVICE PROJECT 3 (2004), available at <http://www.brookings.edu/views/papers/200412retirement.pdf>.

66. *Id.* at 4. Iowa applied for a RWJF grant, which was denied; Iowa established its own LTCIP Program anyway. See IOWA DEPT. OF HUMAN SVCS., IOWA MEDICAID ENTER., LONG-TERM CARE ASSET DISREGARD INCENTIVE PROGRAM, <http://www.ime.state.ia.us/docs/LTC-asset-disregard.doc> (last visited Sept. 26, 2007).

67. Ahlstrom et al., *supra* note 65, at 4.

68. *Id.*

subject to estate recovery programs, the state will initially disregard the shielded assets when evaluating a Medicaid applicant's available resources.⁶⁹ Consumers are free to purchase as much or as little LTC insurance as they wish, and the asset-shielding power of the program varies accordingly.⁷⁰

The "Total Asset Protection" model, which New York adopted, offers a kind of all-or-nothing approach.⁷¹ To shield any assets, consumers have to purchase a minimum amount of insurance, enough to pay for three years of institutional care, six years of home care, or some combination of the two.⁷² Consumers with lesser coverage have no assets shielded from counting under the resource rules.⁷³ However, if a consumer purchases the required minimum amount, the state disregards all of the consumer's assets when he or she applies for Medicaid coverage.⁷⁴ This approach requires larger policies at higher premiums, but offers more potential leveraging power to those able and willing to buy such policies.⁷⁵

Other states have adopted both approaches. Indiana enacted a hybrid model, offering dollar-for-dollar protection for smaller policies and total asset protection upon purchase of the three-year policy.⁷⁶ Iowa utilizes a dollar-for-dollar approach.⁷⁷ All five programs included required five percent compound annual inflation protection.⁷⁸

Almost immediately, the programs raised concerns on a

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *See id.*

74. *Id.*

75. *See id.*

76. *Id.*; *see generally* ALLIANCE FOR HEALTH REFORM, LONG-TERM CARE PARTNERSHIPS: AN UPDATE, 1-2 (2007), http://www.allhealth.org/Publications/Long-term_care/Long_Term_Care_Partnerships_53.pdf (last visited Sept. 26, 2007) (providing program implementation statistics for Indiana).

77. *See* Ahlstrom et al., *supra* note 65, at 3.

78. U.S. GOV'T ACCOUNTABILITY OFFICE, LONG-TERM CARE INSURANCE: PARTNERSHIP PROGRAMS INCLUDE BENEFITS THAT PROTECT POLICYHOLDERS AND ARE UNLIKELY TO RESULT IN MEDICAID SAVINGS 21 (2007), *available at* <http://www.gao.gov/new.items/d07231.pdf>.

number of levels. Some critics feared that the programs offered the wealthy an easy and cheap asset shelter, which would actually increase Medicaid spending for the wealthy, while failing to provide any incentive for less wealthy elders to purchase the insurance.⁷⁹ Other critics worried that the inflation protection levels were either too high for market realities or too low to ensure sufficient benefits over time, or that other policy aspects might prove problematic.⁸⁰ Still others thought that the lack of protection from estate recovery programs effectively undercut the incentive to purchase the insurance.⁸¹ In response to the concerns raised, Congress halted additional pilot programs in 1993.⁸²

The DRA lifted the 1993 embargo and set out the following guidelines to govern state implementation of LTCIP Programs:

- Programs may be implemented via the SPA process rather than through a 1902(r)(2) waiver.⁸³
- New programs must follow the "Dollar-for-Dollar" model.⁸⁴
- States may exempt the shielded benefits from estate recovery.⁸⁵
- Home equity in excess of the state cap will not be protected even if the applicant has an otherwise qualifying policy.⁸⁶
- Qualifying policies must comply with the National

79. See Ahlstrom et al., *supra* note 65, at 3.

80. See MILA KOFMAN & LEE THOMPSON, GEORGETOWN UNIV. LONG-TERM CARE FINANCING PROJECT, CONSUMER PROTECTION AND LONG-TERM CARE INSURANCE: PREDICTABILITY OF PREMIUMS 2-5 (2004), <http://www.ltc.georgetown.edu/pdfs/consumer.pdf> (last visited Sept. 26, 2007).

81. See generally Ahlstrom et al., *supra* note 65, at 3 (discussing the dollar-for-dollar approach and states that have adopted it).

82. *Id.*

83. CTRS. FOR MEDICARE & MEDICAID SERVS., QUALIFIED LONG-TERM CARE PARTNERSHIPS UNDER THE DEFICIT REDUCTION ACT OF 2005, ENCLOSURE 2 (2006), available at www.cms.hhs.gov/smdl/downloads/LTCEnclosure.pdf [hereinafter QUALIFIED LONG-TERM CARE PARTNERSHIPS].

84. ALLIANCE FOR HEALTH REFORM, *supra* note 76, at 2.

85. QUALIFIED LONG-TERM CARE PARTNERSHIPS, *supra* note 83, at 2.

86. ALLIANCE FOR HEALTH REFORM, *supra* note 76, at 3.

Association of Insurance Commissioners' *Long Term Care Insurance Regulations and Model Act*, which imposes a variety of consumer protection requirements.⁸⁷

- Policies sold to individuals younger than sixty-one must include compound inflation protection, while policies sold to individuals between ages sixty-one and seventy-six must include some level of inflation protection. Policies sold to individuals older than seventy-six may, but are not required, to include any inflation protection.⁸⁸

The Secretary of Health and Human Services is charged with developing a standard program for reciprocal recognition of qualified coverage from state to state and with establishing a clearinghouse for information about long-term care generally.⁸⁹ The LTCIP Programs in place prior to the DRA are grandfathered in, so long as they provide consumer protection that is at least as extensive as required under the DRA.⁹⁰

States have responded enthusiastically to the new LTCIP Program options.⁹¹ The five pre-DRA programs will continue under the grandfather provisions.⁹² By early summer 2007, at least Minnesota and Idaho⁹³ had federal approval for their

87. QUALIFIED LONG-TERM CARE PARTNERSHIPS, *supra* note 83, at 3.

88. CROWLEY, *supra* note 33, at 7.

89. *See id.* at 1.

90. *See* ALLIANCE FOR HEALTH REFORM, *supra* note 76, at 2.

91. *Id.*

92. *See id.*

93. It has been curiously difficult to locate accurate information about the status of state programs at any particular moment. According to a State Medicaid Director Letter dated July 27, 2006, states must get an LTCIP Program approved by CMS under an SPA; but, "[a] SPA that provides for a Qualified State LTC Insurance Partnership under the amended section 1917(b)(1)(C) of the Act may be effective for policies issued on or after a date specified in the SPA, but not earlier than the first day of the first calendar quarter in which the SPA is submitted." QUALIFIED LONG-TERM CARE PARTNERSHIPS, *supra* note 83, at 4. The CMS website does not catalog SPA submissions not yet approved, and individual state Medicaid pages vary in how much information they provide to the public. Phone call inquiries to CMS resulted in being shuffled around to various departments which were unable to provide insightful answers, and voicemail messages left asking for guidance on this topic were likewise unreturned.

programs,⁹⁴ while at least sixteen additional states had enacted legislation that approved such programs and required state officials to submit appropriate SPA applications, either as soon as possible or by stated deadlines.⁹⁵ Similar authorizing legislation was pending in an additional twelve states.⁹⁶

There are still uncertainties about LTCIP programs. There is not yet enough data to be certain such a product will catch on with consumers.⁹⁷ As of 2005, such LTCIP program policies were paying for only about 3% of all long-term care spending.⁹⁸ As of mid-2006, the number of qualifying policies sold in all pre-DRA states totaled less than 250,000.⁹⁹ At that time, only 3,822 policies had paid benefits, and of those, only 175 policyholders had exhausted their insurance benefits and accessed Medicaid, thereby enjoying the asset protection elements of the programs.¹⁰⁰

However, the added prohibition on estate recovery may encourage more consumers to purchase LTCIP policies.¹⁰¹ States are also beginning to market the policies much more aggressively, which may boost sales.¹⁰² Still, if the Americans

94. See Minn. Dept. of Human Servs., Minnesota Long Term Care Partnership, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137036 (last visited Sept. 26, 2007); see also Idaho Dept. of Ins., Idaho Long Term Care Partnership, http://www.doi.idaho.gov/company/LTC_partnership.aspx (last visited Sept. 26, 2007).

95. See Appendix 1. See the following states: Arkansas, Florida, Georgia, Idaho, Illinois, Kansas, Maryland, Missouri, Montana, Nebraska, Ohio, Oklahoma, Pennsylvania, Rhode Island, Texas, and Virginia.

96. See Appendix 1. See the following states: Colorado, Hawaii, Maine, Massachusetts, Michigan, Nevada, North Dakota, Oregon, Tennessee, Vermont, Washington, and Wisconsin.

97. See ALLIANCE FOR HEALTH REFORM, *supra* note 76, at 4.

98. *Id.* at 1. See generally DAVID C. NIXON, UNIV. OF HAWAII AT MANOA, COLLEGE OF SOCIAL SCI. PUB. POLICY CTR., STATE PROGRAMS TO ENCOURAGE LONG-TERM CARE INSURANCE 9-14 (2006), available at <http://www.publicpolicycenter.hawaii.edu/documents/paper001.pdf> (discussing considerations involved when adopting a long-term care insurance program); Ahlstrom et al., *supra* note 65, at 5-11 (evaluating the development, improvement, and future of partnership programs).

99. ALLIANCE FOR HEALTH REFORM, *supra* note 76, at 2.

100. *Id.*

101. See *id.*

102. See Ahlstrom et al., *supra* note 65, at 7.

who end up relying on Medicaid for their long-term care are not attracted to LTCIP policies, or if they cannot afford the policies, then the LTCIP policies may arguably have only a limited impact on actual Medicaid expenditures.

SECTION 6086 – EXPANDED HOME AND COMMUNITY BASED SERVICES PROGRAMS

Section 6086 of the DRA expands states' ability to provide home-and community-based services (HCBS) without requiring approval under the pre-DRA waiver process.¹⁰³ States will be able to have CMS approve such expanded services under the new SPA process.¹⁰⁴ Through the SPA process, CMS may authorize states to provide any of the services previously covered under HCBS waivers.¹⁰⁵

Prior to the DRA, applicants for HCBS had to demonstrate that but for the HCBS they would be compelled to seek care in an institution.¹⁰⁶ This rule has changed.¹⁰⁷ Under the new SPA-based HCBS programs, states must make it easier for applicants to qualify for HCBS while also making it more difficult for applicants to qualify for institutional-based care.¹⁰⁸

States can provide services through existing, pre-DRA HCBS waiver programs so long as the SPA program does not duplicate services offered under the waiver, and Medicaid beneficiaries may qualify for services under both programs.¹⁰⁹ In addition, states may elect to waive community deeming rules

103. DISABILITY POLICY COLLABORATION, P'SHIP OF THE ARC & UNITED CEREBRAL PALSY, THE DEFICIT REDUCTION ACT OF 2005 1 (2006), *available at* http://www.ucp.org/uploads/Deficit_Reduction_Act_of_2005_March_06.doc.

104. ROBERT L. MOLLIKA, CMTY. LIVING EXCH. COLLABORATIVE, INST. FOR HEALTH, HEALTH CARE POLICY, AND AGING RESEARCH, DEFICIT REDUCTION ACT: HCBS STATE PLAN OPTION, DRAFT FOR BACKGROUND AND DISCUSSION 1-2 (2006), *available at* http://www.adrc-tae.org/tiki-download_file.php?fileId=2443&PHPSESSID=6341b9ca6306de4d033a7d540197fbc5.

105. DISABILITY POLICY COLLABORATION, *supra* note 103, at 1.

106. *See* CROWLEY, *supra* note 33, at 12-13.

107. *Id.*

108. *Id.* at 13.

109. MOLLIKA, *supra* note 104, at 1-2; *see* DISABILITY POLICY COLLABORATION, *supra* note 103, at 2.

and instead use institutional deeming rules for measuring income.¹¹⁰ States may also choose to offer HCBS through either agencies or a self-directed benefit program.¹¹¹

Some of the services that states may cover in a SPA-based HCBS program include: personal attendant care, homemaker services, chore services, home-delivered meals, companion services, adult day care, respite care, adaptive equipment, home modifications, safety or communication devices, transportation, personal emergency response systems, environmental accessibility adaptations, prescription drugs, co-pays for medical visits, durable medical equipment not covered by Medicaid, and discretionary spending.¹¹² The new SPA-based HCBS program provisions are designed to increase access to HCBS.¹¹³ To the extent that such an increase in access suits an elder's needs and preferences while also saving states' money, the SPA-based programs seemingly will offer advantages over the pre-DRA HCBS programs.

However, states may also impose enrollment limits on the new programs.¹¹⁴ While other Medicaid programs have required states to offer benefits to all residents, states do not have to implement the new SPA-based HCBS programs statewide.¹¹⁵ In addition, SPA-based programs, unlike waiver programs, are not required to demonstrate "budget neutrality," or that the services were equivalent alternatives to institutional care and not merely strategies to cut costs.¹¹⁶ States can also

110. See, e.g., CAL. DEPT. OF DEVELOPMENTAL SERVS., THE HOME AND COMMUNITY-BASED SERVICES WAIVER FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, <http://www.dds.ca.gov/publications/pdf/HCBSBrochureRevised904.pdf> (last visited Sept. 26, 2007) (explaining the deeming rules for California's HCBS waiver).

111. See CROWLEY, *supra* note 33, at 13.

112. *Id.* at 18 n. 20.

113. See *id.* at 12.

114. DISABILITY POLICY COLLABORATION, *supra* note 103, at 2-3.

115. *Id.* at 2.

116. NAT'L CONSORTIUM FOR HEALTH SYS. DEV., THE DEFICIT REDUCTION ACT OF 2005: A SUMMARY FOR MEDICAID INFRASTRUCTURE GRANTS 2 (2006), available at http://www.nchsd.org/AccessDocument.cfm?document=DRA_NCHSDBackgroundBrief.pdf.

maintain waiting lists for the HCBS.¹¹⁷

In addition to the more stringent qualification requirements for institutional care, applicants may be denied services when they are too self-sufficient to qualify for institutional care, but meet the need requirements for home or community care, as applicants can be relegated to a waiting list.¹¹⁸ Furthermore, if enrollment exceeds anticipated levels, states may establish more stringent eligibility criteria upon sixty days notice without any additional CMS approval process.¹¹⁹ Beneficiaries of HCBS, who do not satisfy the more strict criteria, are grandfathered in for only one year, which runs from the initial provision of HCBS, not from the date that the increased criteria were imposed.¹²⁰ Thus, while states must offer SPA-based HCBS programs to all beneficiaries, states can limit participation of some groups simply by tailoring the benefits offered.¹²¹

In April, Iowa became the first state to receive CMS approval of a SPA-based HCBS program.¹²² That program appears to provide benefits only to individuals with psychiatric needs.¹²³ Elder Iowans continue to have access to a waiver-based HCBS program.¹²⁴

The new SPA-based HCBS provisions do not affect long-term care on their face, but they will likely have a profound impact on elders who either currently receive long-term care in an institutional setting, or who develop needs that would have

117. DISABILITY POLICY COLLABORATION, *supra* note 103, at 2.

118. See NAT'L CONSORTIUM FOR HEALTH SYS. DEV., *supra* note 116, at 2-3.

119. MOLLIKA, *supra* note 104, at 3

120. *Id.*; POLICY COLLABORATION, *supra* note 104, at 2.

121. MOLLIKA, *supra* note 104, at 3.

122. U.S. DEPT. OF HEALTH AND HUMAN SERVS., HHS APPROVES IOWA AS FIRST TO ADD HOME AND COMMUNITY-BASED SERVICES TO MEDICAID STATE PLAN 1 (April 5, 2007), <http://www.hhs.gov/news/press/2007pres/20070405.html> (last visited Sept. 26, 2007).

123. See NAT'L COUNCIL FOR CMTY. BEHAVIORAL HEALTHCARE, IOWA FIRST TO ADD HOME- AND COMMUNITY-BASED SERVICES OPTION TO MEDICAID STATE PLAN 1 (2007), http://nccbh.browsermedia.com/cs/public_policy/iowa_hcbs (last visited Sept. 26, 2007).

124. See IOWA DEP'T OF HUMAN SERVS., IOWA MEDICAID ENTER., MEDICAID HOME AND COMMUNITY BASED SERVICES CONSUMER CHOICES OPTION 1 (2007), <http://www.ime.state.ia.us/docs/CCObooklet11807.pdf> (last visited Sept. 26, 2007).

qualified them for institutional care prior to the DRA changes.¹²⁵ It seems likely that fewer elders will qualify to have institutional care paid for by Medicaid; it is less clear whether this will actually affect the number of people who need a service, and whether those in need will actually qualify for benefits under the new regime.¹²⁶

Some other uncertainties include: (1) whether individuals can qualify for services under both a waiver program and a SPA program if a state has both programs; (2) what programs will be available to the medically needy, as opposed the categorically needy; (3) whether state programs can include additional services other than those listed; and (4) whether states may tailor waiver and SPA programs so that the two provide services to different groups simultaneously based on need.¹²⁷

SECTION 6087 "PERSONAL ASSISTANCE SERVICES" AND THE SELF-DIRECTED OPTION UNDER SECTION 6086, "CASH AND COUNSELING"

As noted, states can set up section 6086 HCBS programs either in a traditional Medicaid provision of services format or in the form of a self-directed "individual budget model."¹²⁸ Under the second approach, states assign beneficiaries individual budgets of certain dollar amounts to pay for services that qualify as covered benefits under the plan.¹²⁹ This approach up-ends the traditional system; a beneficiary locates Medicaid-qualified providers, and then he or she relies on those providers to determine what services are needed, as well as what services for

125. See generally CROWLEY, *supra* note 33, at 13-14 (discussing the policy implications of the DRA providing HCBS services options to states).

126. See *id.* at 13.

127. See *id.*; see generally MOLLICA, *supra* note 104, at 4 (discussing SPA evaluation and assessment).

128. CROWLEY, *supra* note 33, at 14-16.

129. BRENDA C. SPILLMAN ET AL., HENRY J. KAISER FAMILY FOUND., BEYOND CASH AND COUNSELING: THE SECOND GENERATION OF INDIVIDUAL BUDGET-BASED COMMUNITY AND LONG-TERM CARE PROGRAMS FOR THE ELDERLY 1, 5 (2007), http://www.cashandcounseling.org/resources/20070514-131019/Second_Generation.pdf (last visited Sept. 26, 2007).

which the provider will be paid by the program.¹³⁰ The provider is paid so long as the services meet Medicaid guidelines, which usually means that the services are deemed “medically necessary.”¹³¹ Regulations set forth what is considered a reasonable course of treatment, and Medicaid personnel review billings to ensure variations are medically justified; there is no limit to the services or benefits that can be supplied, so long as they were necessary, and so long as other guidelines are satisfied.¹³² Such “Cash & Counseling” options permit states to shift this model to require Medicaid participants to become more active consumers of their services.¹³³

Under section 6086 HCBS programs, state programs can provide HCBS under a traditional “agency-provided services” model or the “individual budget” model.¹³⁴ The individual budget model gives beneficiaries greater control over the precise benefits received, but beneficiaries also must accept the increased responsibility of that control.¹³⁵ Beneficiaries must manage their own care, which includes everything from identifying appropriate providers to figuring out how to obtain needed services while staying within their budgets.¹³⁶ Under the individual budget approach, the Medicaid beneficiary must figure out how to stretch Medicaid dollars far enough to pay for all needed or desired care.¹³⁷

In addition, section 6087 established a new state option for self-directed personal assistance services (PAS).¹³⁸ Section 6087 allows states to offer HCBS-qualified beneficiaries certain personal assistance, which can include personal attendant care, homemaker assistance, chore services, companion services, and

130. *Id.* at 6-7.

131. *Id.*

132. See generally HERZ ET AL., *supra* note 1, at 18 (discussing state program standards imposed by the federal government).

133. BRENDA C. SPILLMAN ET AL., *supra* note 129, at 7-8.

134. *Id.* at 10.

135. *Id.* at 1-2, 5-6.

136. *Id.* at 5.

137. CROWLEY, *supra* note 33, at 16.

138. DISABILITY POLICY COLLABORATION, *supra* note 103, at 2.

home-delivered meals.¹³⁹ Programs that offer self-directed PAS must require a written plan of care and budget for the participants.¹⁴⁰ Beneficiaries who live in homes or property owned, operated, or controlled by a service provider are prohibited from using self-directed PAS budgeted funds for housing.¹⁴¹ However, beneficiaries can hire, fire, supervise, and manage the people providing them services.¹⁴² If the state program permits, beneficiaries may use and compensate family members to provide services.¹⁴³

States ultimately are responsible for the health and safety of PAS participants, as well as for monitoring the quality and fiscal integrity of their Medicaid programs.¹⁴⁴ States must set appropriate individual budget levels and availability of beneficiary services and the law requires states to offer support systems to help beneficiary participants develop and manage their plans of care.¹⁴⁵ In addition, states will have to find a way to monitor the quality of participant-directed services without undercutting beneficiary choice.¹⁴⁶

Prior to the DRA, "Cash and Counseling" programs operated under either a section 1115 waiver or a section 1915(c) waiver.¹⁴⁷ Ten states currently operate such programs.¹⁴⁸ The two program types vary little in the choices available to beneficiary participants in regards to hiring care-workers, although some states have stricter rules regarding what choices

139. BRENDA C. SPILLMAN ET AL., *supra* note 129, at 11, t.1.

140. CROWLEY, *supra* note 33, at 10-11.

141. DISABILITY POLICY COLLABORATION, *supra* note 103, at 3.

142. *Id.* at 2-3; see BRENDA C. SPILLMAN ET AL., *supra* note 129, at 7.

143. DISABILITY POLICY COLLABORATION, *supra* note 103, at 3.

144. BRENDA C. SPILLMAN ET AL., *supra* note 129, at 8-9.

145. *Id.*

146. CROWLEY, *supra* note 33, at 11.

147. See BRENDA C. SPILLMAN ET AL., *supra* note 129, at 6.

148. The states with either section 1115 waivers or section 1915(c) waivers include Arkansas, Colorado, Florida, Massachusetts, Minnesota, New Jersey, North Carolina, Oregon, South Carolina, and Wisconsin. Massachusetts is currently functioning under a pilot program designed to eventually support a section 1915 waiver application. See *id.* at 11-15, t.1.

a beneficiary's agent can make.¹⁴⁹ For example, in Wisconsin an agent may make the health care choices for a beneficiary only when the beneficiary has a court-appointed guardian or a power of attorney in place.¹⁵⁰ In addition, states with section 1115 programs like Arkansas often allow participant beneficiaries to use a percentage of their monthly allowance on discretionary items.¹⁵¹ Some section 1115 plans also permit participants to save, or "roll over," monthly amounts in order to purchase more expensive items, but require that the amount must be spent on the item requested.¹⁵² In contrast, under South Carolina's section 1915 program participant beneficiaries cannot carry over unused funds into the next allowance period.¹⁵³

As of this writing, it appears that there are no states actively working on implementing SPA-approved individual budget plans under either section 6086 or section 6087. The Kaiser Commission on Medicaid and the Uninsured prepared an in-depth study of pre-DRA "Cash and Counseling" programs and their effectiveness.¹⁵⁴ It remains to be seen whether the DRA embodiment will catch on with the states.

SECTION 6071: MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION GRANTS

Several sections of the DRA do not authorize changes to the substantive Medicaid programs and instead give states an opportunity to compete for grants to help cover innovation costs.¹⁵⁵ Grants under section 6071 are intended to encourage states to move beneficiaries out of institutions and into

149. See BRENDA C. SPILLMAN ET AL., *supra* note 129, at 6-7.

150. *Id.* at 62.

151. *Id.* at 10.

152. See *id.* at 11-12, tbl.1.

153. *Id.* at 12 tbl.1.

154. See BRENDA C. SPILLMAN, ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, BEYOND CASH AND COUNSELING: AN INVENTORY OF INDIVIDUAL BUDGET-BASED COMMUNITY LONG TERM CARE PROGRAMS FOR THE ELDERLY (2006), <http://www.kff.org/Medicaid/upload/7485.pdf> (last visited Sept. 3, 2007).

155. See Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. 1396a).

community settings.¹⁵⁶ Under section 6071, states are eligible for two to five-year competitive grants that would provide an enhanced federal medical assistance percentage (FMAP), which would help the state provide services to beneficiaries who choose to move from an institution to a community setting for up to one year after leaving.¹⁵⁷ The higher FMAP will "equal the state's regular FMAP, plus half of the difference between the regular FMAP and 100%," with matching capped at 90% total.¹⁵⁸ Appropriations for section 6071 "Money Follows the Person" (MFP) grants are allocated as follows: \$250 million for January 1 through September 30, 2007 for fiscal year 2007; \$300 million for 2008; \$350 million for 2009; \$400 million for 2010; and \$450 million for 2011.¹⁵⁹

As of June 1, 2007, CMS reported that it has awarded \$1,435,709,479 in grants to thirty-one states.¹⁶⁰ The MFP grants do not actually affect benefits or criteria for institutionalized long-term care patients. However, the MFP grants, coupled with the availability of SPA-based HCBS programs, seem to indicate a push to transition as much elder care as possible out of institutions and into alternate settings.

NEW SUBSTANTIVE PROGRAM OPTIONS AFFECTING ELDERS

Not long ago, "long-term care" for elders was synonymous with "skilled nursing facility care."¹⁶¹ Older Americans who were able to care for themselves lived on their own or with extended family, and those who were unable to care for themselves

156. DISABILITY POLICY COLLABORATION, *supra* note 103, at 2.

157. *Id.*

158. *Id.*

159. *Id.*

160. See CTRS. FOR MEDICARE & MEDICAID SERVS., MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION 1 (2007), http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFP_FactSheet.pdf (last visited Sept. 26, 2007). For more detailed information about state grants, see MONEY FOLLOWS THE PERSON GRANTS, *supra* note 52.

161. See ALLIANCE FOR HEALTH REFORM, COVERING HEALTH ISSUES 93 (2006), available at <http://www.allhealth.org/sourcebook2006/pdfs/sourcebook2006.pdf>.

moved into skilled nursing facilities, usually for the remainder of their lives.¹⁶² When an elder moved into a skilled nursing facility, it usually created a critical, final economic crisis that prompted eventual reliance on Medicaid.¹⁶³ As a result, for most Americans, Medicaid became synonymous with long-term care in a skilled nursing facility.¹⁶⁴

While some state options under the DRA have the potential to affect elders who already live in skilled nursing facilities, the more telling aspect of the DRA is its clear push to shift Medicaid's long-term care focus away from institutional settings.¹⁶⁵ This shift will likely mean that every state option, even those that do not affect non-institutional care on their face, will affect the long-term care of older Americans. Although the shift was occurring before the DRA went into effect, there is no doubt that long-term care and Medicare reliance no longer implicates only institutional care.¹⁶⁶ Elder law attorneys and advocates should not assume that any particular portion of Medicaid law is definitely inapplicable to elder Americans needing long-term care because drawing such rigid boundaries is dangerous, even if it appears technically correct.

In particular, the DRA includes three concepts that deserve further scrutiny, even though they may appear to have a lesser impact on elders than the ideas previously discussed. First is the imposition of premiums and cost-sharing requirements authorized under sections 6041 and 6042.¹⁶⁷ Second, the so-called Benchmark Benefits Option is a radical overhaul of benefit

162. JUDITH KASPER & MOLLY O'MALLEY, KAISER COMM'N ON MEDICAID AND THE UNINSURED, CHANGES IN CHARACTERISTICS, NEEDS, AND PAYMENT FOR CARE OF ELDERLY NURSING HOME RESIDENTS: 1999 TO 2004, (2007), <http://www.kff.org/medicaid/upload/7663.pdf> (last visited Sept. 26, 2007).

163. KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID AND LONG-TERM CARE SERVICES 1-2 (2006), <http://www.kff.org/medicaid/upload/Medicaid-and-Long-Term-Care-Services-PDF.pdf> (last visited Sept. 26, 2007).

164. *Id.*

165. CLAUDIA WILLIAMS ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, PROFILES OF NURSING HOME RESIDENTS ON MEDICAID 1 (2006), <http://www.kff.org/medicaid/upload/7510.pdf> (last visited Sept. 26, 2007).

166. *Id.* at 1.

167. See DISABILITY POLICY COLLABORATION, *supra* note 103, at 4-5.

structure under section 6044, and it is proving to be popular with states.¹⁶⁸ Finally, states are beginning to experiment with Health Opportunity Accounts made possible under section 6082.¹⁶⁹

**SECTIONS 6041 AND 6042: STATE OPTION FOR ALTERNATIVE
MEDICAID PREMIUMS AND COST SHARING, AND SPECIAL RULES
FOR COST SHARING FOR PRESCRIPTION DRUGS**

Medicaid beneficiaries already have some cost-sharing obligations in the form of small premiums or low co-pays for certain services or prescriptions.¹⁷⁰ Section 6041 allows states to increase cost-sharing for any beneficiary group.¹⁷¹ While cost-sharing increases are subject to limitations, states can impose them on beneficiaries in the form of co-payments or premiums for any item or service, including drugs, equipment, hospital charges, office visits, or therapy sessions.¹⁷²

While the DRA does not include co-pay or premium guidelines, the Secretary of Health and Human Services has stated that state plan amendments will not be approved if the plans charge beneficiaries whose incomes are below the federal poverty level (FPL) with more than a nominal co-pay.¹⁷³ States cannot charge premiums to beneficiaries who have incomes between 100% and 150% of the FPL.¹⁷⁴ However, states can require this group to pay up to 10% of the cost of each item or service, which may include prescription drugs, up to a maximum cost-sharing responsibility of 5% of total family income.¹⁷⁵ States may also require beneficiaries whose income is

168. See *id.* at 6-7; see also NAT'L CONSORTIUM FOR HEALTH SYS. DEV., *supra* note 116, at 3.

169. Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. §§1396v, u-8).

170. See HERZ ET AL., *supra* note 1, at 8-9.

171. DISABILITY POLICY COLLABORATION, *supra* note 103, at 4-5.

172. *Id.* at 4.

173. *Id.*

174. *Id.* at 5.

175. *Id.*

in excess of 150% of FPL to pay up to 20% of the cost of each item or service, up to 5% of the total family income.¹⁷⁶ Section 6041 also permits states to allow Medicaid providers to refuse services to beneficiaries who fail to pay the required co-pay up front.¹⁷⁷ States may give providers complete discretion as to the application of this “pay first” rule.¹⁷⁸

State plans cannot require beneficiaries who live in institutional settings to pay premiums.¹⁷⁹ However, Medicaid participants who would have entered a skilled nursing facility in the past are more likely to receive HCBS under the DRA, and there seems to be no inherent bar to the state imposing the increased cost-sharing measures onto HCBS program enrollees.¹⁸⁰

Section 6042, like section 6041, allows states to impose cost-sharing onto enrolled beneficiaries.¹⁸¹ Under section 6042, states can adopt differential cost-sharing responsibility for non-preferred prescription drugs.¹⁸² Although section 6042 caps co-pays for non-preferred drugs at twenty percent of the drug’s cost, states can reduce or waive co-pays for preferred drugs.¹⁸³ States have the authority to determine which drugs are preferred or non-preferred.¹⁸⁴ States can also waive the higher non-preferred co-pay if a beneficiary’s doctor determines that the preferred drug is ineffective or causes adverse side effects.¹⁸⁵

As of this writing, Kentucky has received approval of a SPA that takes advantage of the DRA’s new cost-sharing opportunities.¹⁸⁶

176. *Id.*

177. *Id.*

178. *See id.*

179. *Id.*

180. *Id.*; see generally CLAUDIA WILLIAMS ET AL., *supra* note 165, at 1 (noting how the DRA will potentially impact the provision of nursing home care).

181. *See* DISABILITY POLICY COLLABORATION, *supra* note 103, at 5.

182. *Id.*

183. *Id.*

184. *Id.*

185. *Id.*

186. Letter from Roger Perez, Acting Reg’l Adm’r, Ctrs. for Medicare & Medicaid Servs., to Shannon R. Turner, Comm’r, Cabinet for Health and Family

SECTION 6044: USE OF BENCHMARK BENEFIT PACKAGES

Section 6044 gives states the option to offer "benchmark" or "benchmark-equivalent" health care benefits to certain beneficiary groups.¹⁸⁷ This benchmark concept involves allowing state Medicaid plans to model themselves after dominant medical insurance plans, termed benchmark models.¹⁸⁸ In theory, a state no longer has to justify to CMS every proposed program variation so long as it uses one of the four acceptable benchmark models.¹⁸⁹

The acceptable benchmark plans are the Federal Employee Health Benefits Plan standard Blue Cross/Blue Shield preferred provider option, any state employee plan generally available in a state, the HMO plan that has the largest, commercial non-Medicaid enrollment in the state, or any plan the Secretary of Health and Human Services deems appropriate.¹⁹⁰

By using the benchmark option, a state may radically revise the structure and terms of its Medicaid program by using a "check the box" pre-printed SPA form, a possibility scarcely imaginable under the pre-DRA waiver processes.¹⁹¹ Despite the use of the term "benchmark," section 6044 benchmark plans are only required to offer benefits that are actuarially equivalent to a benchmark model, and they do not have to offer the same benefits on the same terms.¹⁹²

States may require participation in their benchmark benefit plans, although certain specified high-needs groups are exempt

Servs., Dep't for Medicaid Servs. (May 3, 2006), available at <http://www.chfs.ky.gov/NR/rdonlyres/4E71626B-24D3-4251-B582-625EB8ED5C1E/0/SPA06006approved04052007.pdf>.

187. Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. §§ 1396u-7, v); DISABILITY POLICY COLLABORATION, *supra* note 103, at 6.

188. See DISABILITY POLICY COLLABORATION, *supra* note 103, at 6.

189. See SOLOMON, *supra* note 34, at 2.

190. DISABILITY POLICY COLLABORATION, *supra* note 103, at 6-7.

191. See, e.g., KANSAS ALTERNATIVE BENEFITS STATE PLAN AMENDMENT BENCHMARK BENEFIT PACKAGE 1 (2006), available at http://www.nchsd.org/AccessDocument.cfm?document=KS_SPA_BenchmarkBenefits.doc.

192. See Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. 1396u-7); see also SOLOMON, *supra* note 34, at 1-3, 5.

from compulsion.¹⁹³ Additional options not previously available to states before the DRA include the ability of a state to make a revised benefit plan available only to certain groups, or to beneficiaries in a certain state area, as well as the ability to vary benefits based on assumptions about the beneficiary's likely needs.¹⁹⁴

Finally, a state may offer benchmark plans as an optional alternative, and it can make enrollment in the plan the default, but it must inform beneficiaries of their right to opt out if participation is not mandated.¹⁹⁵ States may offer benchmark plans to all non-exempt groups.¹⁹⁶ In states that make benchmark plan participation the default, beneficiaries may find themselves inadvertently bound by the plan if they are not aware of the availability of or procedural requirements for, opting out.¹⁹⁷

"Dual eligibles" are one group exempted from mandatory participation in state benchmark plans.¹⁹⁸ Dual eligibles include individuals who are eligible for both Medicare and Medicaid, as well as those who are eligible for Medicaid due to disability.¹⁹⁹ However, disabled Medicaid beneficiaries who qualify for Medicaid based on income are not exempt.²⁰⁰

CMS has approved submitted SPAs, each primarily geared toward the creation of a benchmark plan, from five states; Kentucky, West Virginia, Idaho, Kansas, and Virginia.²⁰¹ CMS has allowed SPA plans submitted by Idaho and Kentucky to enroll exempt beneficiaries without the beneficiaries actively choosing the alternative plan.²⁰² Beneficiaries who want

193. SOLOMON, *supra* note 34, at 2.

194. *See id.*

195. *See id.* at 2-3.

196. *See id.* at 3.

197. *See id.*

198. *See* DISABILITY POLICY COLLABORATION, *supra* note 103, at 7.

199. *See id.*

200. *Id.*

201. *See, e.g.,* STATE PLAN AMENDMENTS, *supra* note 41 (follow individual state hyperlinks).

202. *See id.* (follow Idaho and Kentucky hyperlinks). West Virginia and Virginia

traditional Medicaid coverage, to which they are entitled because of their exempt status, must actively seek out necessary information to compare plans and pursue the opt-out on their own.²⁰³

The potential impact benchmark plans could have on long-term care can be identified by examining the benchmark plan of Kentucky.²⁰⁴ Family Choices is a targeted benefit plan designed for children.²⁰⁵ Optimum Choices and Comprehensive Choices are targeted benefit plans designed for elderly or disabled people who need long-term services, as both groups are statutorily exempted from mandatory participation in a benchmark plan.²⁰⁶

While traditional Medicaid always covers the costs of long-term care in a skilled nursing facility or in the community for those who qualify, Kentucky's benchmark plans do not.²⁰⁷ While the Optimum and Comprehensive Choices plans offer acute services on par with traditional Medicaid, coverage of long-term care services is not guaranteed; long-term care coverage depends entirely on the state's assessment of need, and not on any CMS-controlled standards.²⁰⁸ In some cases, Kentucky beneficiaries may receive more services and benefits under the Choices plan than under traditional Medicaid, and in other cases, the benefits will be fewer.²⁰⁹ The benchmark plan's only guarantee is that needs will be assessed.²¹⁰

do not appear to be enrolling exempt elders automatically. Kansas is not enrolling anyone older than 64. *See id.*

203. *See* SOLOMON, *supra* note 34, at 3-5. However, this procedure arguably violates CMS guidelines issued March 31, 2006. Letter from Dennis G. Smith, Dir., Ctrs. for Medicare and Medicaid Servs., to State Medicaid Dir. 3 (Mar. 31, 2006), available at <http://www.cms.hhs.gov/smdl/downloads/SMD06008.pdf>.

204. *See* STATE PLAN AMENDMENTS, *supra* note 41 (follow Kentucky hyperlink).

205. KAISER COMM'N ON MEDICAID AND THE UNINSURED, KENTUCKY HEALTH CHOICES MEDICAID REFORM 1 (2006), <http://www.kff.org/medicaid/upload/7530.pdf> 2 (last visited Sept. 26, 2007); *see also* SOLOMON, *supra* note 34, at 3.

206. *See id.* at 2-3; *see also* SOLOMON, *supra* note 34, at 3.

207. SOLOMON, *supra* note 34, at 3-4.

208. *See id.* at 3.

209. *Id.* at 4.

210. *Id.* at 3.

Kentucky Medicaid participants were automatically enrolled in one of the new benchmark plans in 2006.²¹¹ Although the state informed exempt groups of the option to opt out, the state's letter also warned that opting out would result in higher co-payments.²¹² The state did not provide beneficiary participants with benefit information to use to compare the benchmark plans to traditional Medicaid, and the state did not tell beneficiaries that their long-term care services could vary widely, depending on assessment.²¹³

Kentucky is not the only state playing with its cards held close to the vest. Idaho also permits exempt groups to participate in benchmark plans.²¹⁴ The state automatically enrolls all beneficiaries into one of its benchmark plans.²¹⁵ The application form²¹⁶ describes only the benefits available under the benchmark plans, which includes "Basic Plan" and the "Enhanced Plan."²¹⁷ The benefits offered under traditional Medicaid, "Standard Medicaid," are not described in any detail.²¹⁸

Furthermore, the application explains that participation in the benchmark plans is voluntary, but the state's intriguing way of explaining "voluntary" is as follows:

If you are eligible for Medicaid, you have the right to choose the plan that is based on your health needs. Idaho Medicaid offers the Medicaid Basic Plan and the Medicaid Enhanced Plan to meet different health needs. . . . You may choose NOT to enroll in the plan that meets your health needs. You may choose to

211. *Id.* at 4.

212. *Id.*

213. *See id.*

214. *Id.* at 4-5.

215. *See* IDAHO DEP'T OF HEALTH AND WELFARE, MEDICAID INFORMATION FOR PARTICIPANTS, <http://www.healthandwelfare.idaho.gov/site/4046/default.aspx> (last visited Sept. 26, 2007).

216. IDAHO DEP'T OF HEALTH AND WELFARE, APPLICATION FOR ASSISTANCE, available at <http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=185&MIId=10385&wversion=Staging>.

217. *Id.* at 1.

218. *Id.* at 6.

enroll in Standard Medicaid instead. . . If you do not want to enroll in the benefit plan that meets your health needs, you must inform your Self-Reliance worker.²¹⁹

Some criticize these tactics by pointing out that the whole reason Congress exempted certain groups in the first place was because "benefit packages modeled on commercial insurance generally are insufficient for these populations."²²⁰ Whether one agrees with this criticism, and whether one is sympathetic toward Idaho's desire to enroll as many beneficiaries as possible in benchmark plans, describing opting out as a choice "not to enroll in the plan that meets your health needs" seems designed to induce exempt individuals to accept default enrollment. This "pay no attention to the man behind the curtain"²²¹ approach arguably undercuts the very idea of "voluntary" choice that section 6044 purports to safeguard.

SECTION 6082 – HEALTH OPPORTUNITY ACCOUNTS DEMONSTRATION PROGRAMS

Section 6082 of the DRA creates the possibility of Health Opportunity Accounts (HOAs), and is one of the most dramatic approaches to Medicaid reform.²²² For the moment, the HOA option is more or less experimental.²²³ Section 6082 is characterized as a "demonstration program," and CMS can only authorize ten states to utilize the option during the first five years of its availability.²²⁴ During the demonstration program period, individuals who are over sixty-five, who are dual

219. *Id.*

220. THE ILLUSION OF CHOICE, *supra* note 34, at 2.

221. THE WIZARD OF OZ (Metro-Goldwyn-Mayer 1939).

222. See Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. §§ 1396u-8, v).

223. See *id.*; see also EDWIN PARK & JUDITH SOLOMON, CTR. ON BUDGET AND POLICY PRIORITIES, HEALTH OPPORTUNITY ACCOUNTS FOR LOW-INCOME MEDICAID BENEFICIARIES 2-3 (2005), available at <http://www.cbpp.org/10-26-05health.htm>.

224. FAMILIES USA, MEDICAID ALERT, HEALTH OPPORTUNITY ACCOUNTS: WHAT ARE THEY, AND WHY SHOULD STATE ADVOCATES CARE? 1 (2007), available at <http://www.familiesusa.org/assets/pdfs/dra-hoas.PDF>; PARK & SOLOMON, *supra* note 223, at 2-3.

eligibles, and who receive care in an institution may not participate in HOA programs.²²⁵ Section 6082 does not specifically affect long-term care for elders yet,²²⁶ but that does not mean its benefits concept has not affected long-term care.

HOA programs mirror Health Savings Account and Medical Savings Account programs, which have gained recent strong support from private insurers and various government agencies.²²⁷ This approach to health care funding attempts to shift the provision of medical care from the traditional defined benefit model to something akin to a defined contribution model.²²⁸ A similar shift has occurred with retirement benefits in the United States.²²⁹

In the HOA programs, insured beneficiaries must pay a high deductible before traditional Medicaid benefits are provided.²³⁰ The state would deposit a certain dollar amount in an insured beneficiary's account.²³¹ An account's funds may be used to pay qualified health care costs incurred before the deductible is fully met.²³² The deductible is usually the same as, or slightly higher than, the amount deposited.²³³ At this point, the plan appears to be cost-neutral for the insured beneficiary.²³⁴ Although the deductible is high, the burden appears offset by the equal or nearly equal amount of "free money" available to pay the deductible costs.²³⁵

One important change is that "account" type plans have severed their previous relationship between resources and

225. FAMILIES USA, *supra* note 224, at 2. This is in contrast to section 6044, which prohibits *mandatory* participation of exempt persons in a Benchmark Benefit program but does allow *voluntary* enrollment of exempt persons. See Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C.A. §§ 1396u-7, v).

226. *See id.*

227. *See* FAMILIES USA, *supra* note 224, at 1.

228. *See id.* at 3-4.

229. *See id.* at 1.

230. PARK & SOLOMON, *supra* note 223, at 1.

231. *Id.* at 2.

232. *Id.*

233. *Id.* at 1-2

234. *Id.* at 4.

235. *Id.* at 4-5.

benefits.²³⁶ As presently structured under section 6082, the deductible is limited to an amount equal to or slightly higher than the amount deposited in the account, but there is no longer any inherent conceptual link between the two.²³⁷ Once a state HOA program has completed the initial five-year demonstration phase, the program will likely become permanent.²³⁸ And once an HOA program has graduated from the demonstration phase, a state could amend the plan to raise deductibles higher without also increasing the amount on deposit, reduce the amount deposited into the HOA each year, expand the program to require participation by previously exempted groups, such as those 65 years or older, dual eligibles, and those living in an institutional setting, or limit the account's availability to certain groups or locations, while expanding the high deductible's application.²³⁹

At this writing, South Carolina has submitted the only HOA waiver program that has been approved.²⁴⁰ The program comports with the requirements of the DRA, and thus, during the five-year demonstration period, it will not apply to individuals older than sixty-four.²⁴¹ However, it is somewhat confusing that South Carolina is also implementing a benchmark-style plan that includes account-type elements.²⁴² This benchmark-style plan will apply to elders, including elders in long-term care, but with regard to their non-institutional care expenses.²⁴³

236. See FAMILIES USA, *supra* note 224, at 4.

237. *Id.* at 4-5.

238. See *id.* The DRA does provide that the Secretary of HHS may bar this conversion if problems are found, but the presumption is in favor of the program becoming permanent. See PARK & SOLOMON, *supra* note 223, at 3.

239. *Id.*

240. STATE PLAN AMENDMENTS, *supra* note 41 (select South Carolina hyperlink).

241. See CTRS. FOR MEDICARE & MEDICAID SERVS., SOUTH CAROLINA'S STATE PLAN AMENDMENT (2007), available at <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/schoasc07-002FAcTsheets.pdf>.

242. STATE PLAN AMENDMENTS, *supra* note 41 (follow South Carolina hyperlink).

243. See *id.*

CONCLUSION

The Deficit Reduction Act is a complex piece of legislation that modifies an already complex federal law. It offers a myriad of complex options to states that were already operating widely divergent versions of the Medicaid program. In a sort of nightmarish embodiment of how many ways there are to skin a cat, the modern approach to providing health care to the needy is, first and foremost, complex.

Increasing health care costs force consumers to face difficult choices, and the government likewise feels the strain of rising costs. Whether Medicaid was “working” before the DRA became law is irrelevant because, regardless of the ability to get health care to those in need, the costs had reached the point of crippling state budgets. Post-DRA Medicaid is not inherently more complex than pre-DRA Medicaid. States can still choose to adopt different approaches to the various problems they face, all in the hopes of improving health care delivery and reducing health care costs. However, the new state options under the DRA do seem to change the landscape in key ways.

One issue that remains unclear is Congress’ intent and objectives for the Medicaid program in the long term. As an example, consider South Carolina’s use of a pre-DRA section 1115 waiver process to implement a non-DRA compliant approach to Health Opportunity Accounts, which are included among DRA-authorized but limited options.²⁴⁴ When Congress approved the implementation of HOAs under the DRA, it also implemented limitations to safeguard certain eligible groups.²⁴⁵ It is unclear whether Congress realized that states already could ignore safeguards by using a different waiver process for program approval. If Congress intended to allow states to be able to use a different waiver process, which would mean South Carolina did not need to have CMS approve the HOA program by way of the DRA approaches, what is the harm of avoiding

244. See FAMILIES USA, *supra* note 224, at 6.

245. See *id.*

additional burdens that the DRA imposes? Furthermore, it is not clear which of the following Congress intended:

- To merely simplify the process for implementing state options?
- To simplify the process for implementing state options, but only in regard to certain program ideas?
- To simplify the process for implementing certain program ideas, but with certain limitations, thereby implying that limitations are inherently necessary whenever states are excused from the more deliberative pre-DRA waiver processes?
- To simplify the process for implementing certain programs, provided that the programs were subject to specific limitations, but without implying that the limitations are *per se* necessary? Has Congress given implied approval of the new program ideas that do not meet the DRA limitations, so long as the state used the less streamlined waiver processes?

Another problem that may be exacerbated by the DRA relates to how much complexity the federal program can sustain. State legislatures and Medicaid directors may not be intending to "hide the ball" from Medicaid beneficiaries or advocates, but the ball is becoming more difficult to find nonetheless. The implementation of benchmark benefit plans serves as a good example. Although the DRA states what procedures states must follow to implement the benchmark plans in a reasonably clear way,²⁴⁶ two states appear to have implemented default provisions in benchmark plans without clearly informing beneficiaries that the plans are voluntary and that beneficiaries can opt out.²⁴⁷ The DRA does not require states to explain complexities to beneficiaries, and even when state Medicaid materials provide explanations, rarely do they cite to statutory

246. See Pub. L. No. 109-171, § 6071, 120 Stat. 4 (codified as amended at 42 U.S.C.A. §§ 1396v).

247. See SOLOMON, *supra* note 34, at 3-4, 6.

or regulatory authority.²⁴⁸ How can average Medicaid beneficiaries, or average citizens, know they need to challenge a state's Medicaid program when the permissible options and limits are so variable and difficult to understand? Do states really need at least three ways to modify as many as ten different Medicaid benefit options?

The DRA was hailed as a much-needed reform of the Medicaid system, and some of its innovations may well prove to solve some of the pressing problems facing states, particularly those that have developed within the past twenty years.²⁴⁹ But "reform" it is not. The byzantine complexity of state options has mutated the desired "reform" into a Rube Goldberg labyrinth of baling wire and duct tape, perched precariously atop a Terry Gilliam nightmare.²⁵⁰

248. *See generally id.*

249. *See* Press Release, Office of the Press Sec'y, President Bush Signs the Deficit Reduction Act (Feb. 8, 2006), *available at* <http://www.whitehouse.gov/news/releases/2006/02/print/20060208-9.html>.

250. *See* BRAZIL (Twentieth Century Fox 1985).

APPENDIX ONE: STATE LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM UPDATES AND LINKS

State	LCTi Program	Link to State Medicaid Site	Link to LCTI Legislation	Legislation No.
Alabama	No	http://www.medicaid.alabama.gov		
Alaska	No	http://www.hss.state.ak.us/dpa/programs/medicaid/		
Arizona	No	http://www.ahccs.state.az.us		
Arkansas	No	https://www.medicaid.state.ar.us		
California	Yes *	http://www.medi-cal.ca.gov/default.asp	http://www.dhs.ca.gov/cpltc	
Colorado	Yes **	http://www.chopf.state.co.us	http://www.cfmc.org/medicaid/medicaid_index.htm	2007 CO H.B. 1039 (NS)
Connecticut	Yes *	http://www.ctmedicalprogram.com/about.html	http://www.ctpartnership.org	
Delaware	No	http://dhss.delaware.gov/dhss/dss/ltcmedicaid.html		
Florida	Yes ***	http://www.fdhc.state.fl.us/Medicaid/index.shtml	http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=long+term+care+insurance+partnership&URL=CH0627/Sec94075.HTM	
Georgia	Yes ***	http://dch.georgia.gov/02/dch/home/0,2467,3144671,00.html	http://www.legis.state.ga.us/legis/2005_06/fulltext/hb1451.htm	
Hawaii	No	http://www.med-quest.us/eligibility/EligPrograms_MFFS.html		2007 HI S.B. 1410 (NS)
Idaho	Yes ***	http://www.healthandwelfare.idaho.gov/site/3629/default.aspx	http://www.doi.idaho.gov/company/LTC_partnership.aspx	
Illinois	Yes ***	http://www.hfs.illinois.gov/medical/apply.html	http://www.ilga.gov/commission/jcar/admincode/089/089000260sections.html	

Indiana	Yes +	http://www.in.gov/fssa/ltcp/	http://www.in.gov/fssa/ltcp/pdf/booklet.pdf	
Iowa	Yes *	http://www.dhs.state.ia.us/dhs2005/ime/Members/WhatsMedicaid.html		
Kansas	Yes ***	https://www.knap-state-ks.us		2007 KS S.B. 11 (NS)
Kentucky	No	http://chfs.ky.gov/dms/		
Louisiana	No	http://www.dhh.louisiana.gov/offices/?ID=92		
Maine	Yes ***	http://beas.dhs.maine.gov/mainecare		2007 ME S.P. 678 (NS)
Maryland	Yes ***	http://www.dhmr.state.md.us/mma/mmahome.html	http://mgasearch.state.md.us/data/2007rs/bills_noln/hb/thb1160.pdf#xml=VgwKey=j%3A%5C2007rs%5Cbill%5FnoIn%5Cnb%5Cthb1160%2Epdf&doctype=xml&Collection=2007+Bill+text&QueryZip=long+term+care+insurance+partnership&	
Massachusetts	Yes ***	http://www.rwjf.org/reports/gr/015602.htm		2007 MA H.B. 1004 (NS)
Michigan	Yes ***	http://www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html	http://house.michigan.gov/sessiondocs/2005-2006/minutes/shsr091906.pdf	
Minnesota	Yes *	www.medicaidhelp.com/mn/	http://www.dhs.state.mn.us/main/ideplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137036	
Mississippi	No	http://www.dom.state.ms.us/		
Missouri	Yes ***	http://www.dss.mo.gov/dms/recipients.htm	http://www.senate.mo.gov/07info/BTS_Web/Bill.aspx?SessionType=r&BillID=37	
Montana	Yes ***	http://medicaidprovider.hhs.mt.gov/	http://data.opi.mt.gov/bills/2007/billhtml/HB0156.htm	
Nebraska	Yes ***	http://www.hhs.state.ne.us/med/index.htm	http://srvwww.unicam.state.ne.us/unicamAllDrafting.html	

Nevada	No	http://dhcfp.state.nv.us		
New Hampshire	No	http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm		
New Jersey	No	http://www.state.nj.us/human-services/dmahs/dhsmid.html		
New Mexico	No	http://www.hsd.state.nm.us/mad/		
New York	Yes ++	http://www.health.state.ny.us/health_care/medicaid/	http://www.nyspltc.org	
North Carolina	No	http://www.dhhs.state.nc.us/dma/		
North Dakota	Yes ***	http://www.nd.gov/ndins/consumer/details.asp?ID=280		2007 ND S.B. 2124 (NS)
Ohio	Yes – Sept. 2007	http://codes.ohio.gov/orc/5111.18	http://jfs.ohio.gov/Ohp/	
Oklahoma	Yes ***	http://www.ohca.state.ok.us/	http://www.lsb.state.ok.us/	2007 OK H.B. 2021 (NS)
Oregon	Yes ***	http://www.oregon.gov/DHS/healthplan		2007 OR S.B. 191 (NS)
Pennsylvania	Yes ***	http://www.dpw.state.pa.us/OMAP	http://www.legis.state.pa.us/dsearch.asp?cmd=search&searchType=all&words&maxfiles=10&autoStopLimit=1000&sort=Hits&CiScope=20050txt&CiRestriction=long+term+care+insurance+partnership	2007 H.B. 93 P.N. 4815
Rhode Island	Yes +++	http://www.dhs.state.ri.us/	http://www.rilin.state.ri.us/news/pr1.asp?prid=3928	
South Carolina	No	http://www.dhhs.state.sc.us/dhhsnew/index.asp	http://www.franklinassociatesinc.com/current.pdf	
South Dakota	No	http://dss.sd.gov/		

Tennessee	Yes ***	http://www.state.tn.us/tenncare		2007 TN S.B. 216 (NS)
Texas	Yes ***	http://www.hhsc.state.tx.us/medicaid/index.html	http://www.texasinsider.org/modules.php?name=News&file=article&sid=59	
Utah	No	http://health.utah.gov/medicaid		
Vermont	Yes +++	http://www.dsw.state.vt.us/Programs_Pages/Healthcare/medicaid.htm	http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/bills/intro/H-008.HTM	
Virginia	Yes - Sept. 2007	http://www.dmas.virginia.gov/	http://www.dmas.virginia.gov/downloads/pdfs/ab-LTC_Prtm_20Fct_Sheet_07.pdf	
Washington	Yes ***	http://fortress.wa.gov/dshs/maa/		2007 WA H.B. 1086 (NS)
Washington D.C.	No	http://www.acs-gcro.com/Medicaid_Accounts/WashingtonDC_Medicaid/washingtondc_medicad.htm		
West Virginia	No	http://www.wvdhhr.org/bms/		
Wisconsin	Yes ***	http://www.wvdhhr.org/bms/	http://www.legis.state.wi.us/lfb/2007-09budget/Budget%20Papers/400.pdf	
Wyoming	No	http://wyequalitycare.acs-inc.com		

* - Dollar for Dollar ** - Effective January 1, 2008 *** - Enabling Legislation Passed
+ - Hybrid with Reciprocation ++ - Asset Protection/Hybrid +++ - Enabling Legislation Authorized
